MEDICARE SUPPLEMENT FILING SUMMARY

COMPANY NAME: _____

CONTRACT FORM NUMBER: _____ PLAN: _____ (A, B, C, etc.)

CHECK ONE ITEM IN EACH OF THE FOLLOWING SIX BOXES:

TYPE

	Group
	Individual

	Medicare Supplement
	Medicare SELECT

FORM

	Direct Response Marketed
	Agent Marketed

	Guarantee Issue
	Medically Underwritten

	Medicare Eligible by Reason of Age
	Medicare Eligible by Reason of Disability

	Includes New or Innovative Benefits
	Does Not Include New or Innovative Benefits

(Mark One) THIS FILING IS: ☐ (NEW FORM) ☐ (OTHER FORM) ☐ (INITIAL RATE) ☐ (REVISED RATE)

DOCUMENT ATTACHED	DOCUMENT NUMBER
☐ CONTRACT	_____
☐ CERTIFICATE (GROUP COVERAGE ONLY)	_____
☐ OUTLINE OF COVERAGE	_____
☐ APPLICATION	_____
☐ ACTUARIAL MEMORANDUM	_____
☐ SCHEDULE OF RATES	_____
☐ COMPLETE AGENTS COMPENSATION AGREEMENT	_____
☐ ADVERTISING	_____
☐ SCHEDULE OF AGENT/BROKER COMPENSATION	_____
☐ ANNUAL ADJUSTMENT NOTICE	_____
☐ NETWORK PROVIDER LISTING	_____
☐ OTHER: _____	_____